CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

California Performance Review
Health and Human Services Recommendations

Response to Stakeholder Survey
from the
California Association of Public Hospitals and Health Systems
August 16, 2004

The California Association of Public Hospitals and Health Systems (CAPH) represents 22 public hospitals located in 17 counties where 85 percent of Californians live. Californiaís public hospitals form the core of our stateís safety net. Together, though representing only 6 percent of all hospitals in California, public hospitals provide 55 percent of hospital care and over half of hospital-based outpatient visits to the uninsured and more than 30 percent of inpatient and outpatient care to the stateís Medicaid (Medi-Cal) beneficiaries. Public hospitals also operate 62 percent of the stateís Level I trauma centers and train half of the stateís new physicians. As a group, public hospitals employ more than 70,000 California workers.

CAPH appreciates the opportunity to provide initial input to the Health and Human Services Agency regarding the recommendations contained in the CPR and we look forward to participating in the process to improve the effectiveness of health programs that provide access to care for low-income Californians. Our comments focus on recommendations that impact public safety net hospitals and the patients they serve. Due to the extensive scope and variety of recommendations and the limited timeframe of this initial survey, our analysis remains in progress and we do not at this time provide detailed comments on all CPR recommendations of concern to CAPH, including HHS 02: the realignment of certain health and human services as it relates to the provision of indigent care.

HHS 29
Redirect Medi-Cal Hospital Disproportionate Share Payments from Hospitals that are not Providing Core Medi-Cal Services

CPR proposes to redirect Medicaid disproportionate share hospital (DSH) payments by altering the standards by which the funds are distributed. The new criteria would include whether a hospital provides certain ìcore servicesî and has a plan to meet current seismic safety standards. This proposed change is not in line with the core purpose of the DSH program and could unintentionally undermine the effectiveness of DSH funds in maintaining access to care for Medi-Cal beneficiaries and low-income, uninsured Californians.

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The Medicaid DSH program provides supplemental federal Medicaid funds to eligible hospitals for the unreimbursed costs of serving Medi-Cal and uninsured patients. The purpose of Medicaid DSH is to provide special funding to sustain safety net hospitals that treat a disproportionate share of Medicaid and low-income patients so that they may continue to provide access to care for these patients for whom they receive no or inadequate payment.

Medicaid DSH is the foundation of the funding system that supports public hospitals and health systems. Though public hospitals make up only 6 percent of hospitals statewide, they provide 55 percent of inpatient care and more than half of hospital outpatient care to the uninsured. Similarly, the DSH payments are highly concentrated at these core safety-net facilities. Public hospitals could not fulfill this role as major essential providers of care to the uninsured in the absence of DSH funding.

DSH program standards should be aligned with the programís purpose of providing funding to hospitals to help offset losses associated with serving uninsured and Medi-Cal patients. California currently has the most stringent DSH eligibility standards for hospitals in the nation.

CAPH is concerned that the CPR recommendation of determining DSH eligibility based on the hospital providing certain ìcoreî services ñ rather than on the patient population served ó would undermine program integrity and not advance the goal of improving access to care. Some public hospitals could lose DSH funding under the current proposal, which would put them at serious risk of closure and threaten access to care for low-income and uninsured persons in their community, thus negating the very purpose of DSH support. Further, the services a hospital provides should be based on local needs. For example, in a large urban area with multiple safety net hospitals, it may not make sense for each of those hospitals to operate a neo-natal intensive care unit. However, the role of each safety net hospital in serving large numbers of Medi-Cal and uninsured patients remains essential and is appropriately supported by DSH funding.

If it is identified that certain hospital services are not fully available to Medi-Cal beneficiaries, the state could consider more targeted mechanisms to address the concern. It could, for example, improve state funded Medi-Cal hospital rates or timeliness of DSH payments for those services to increase the number of providers offering the service to Medi-Cal beneficiaries.

Transferring Functions of the California Medical Assistance Commission to Health and Human Services (page 14)

Since its establishment over two decades ago**,** the California Medical Assistance Commission (CMAC) has been tremendously successful in helping to ensure access to hospital services throughout the state for low-income Californians. CAPH is highly concerned that abolishing CMAC as an independent body and moving its functions to the Health and Human Services Agency may have the unintended consequence of reducing the stateís effectiveness in achieving the important public policy goal of responding immediately to local market changes and ensuring access to hospital services for Medi-Cal beneficiaries.

CMAC was established as an independent commission to implement the Selective Provider Contracting Program (SPCP). An important role of CMAC is to help address the unique needs of individual hospitals and help ensure access to hospital services for Medi-Cal beneficiaries across the

state. Through a competitive negotiating process, CMAC has been highly effective in seeing that local markets maintain the capacity to meet the hospital needs of Medi-Cal beneficiaries.

CMACís role as an independent negotiating body is critical to fulfilling its functions. Because of the selective and competitive nature of the SPCP in setting Medi-Cal inpatient rates, it is imperative that the negotiator of rates be independent from the payer of those rates. In other words, CMAC and the state must maintain some distance. The independent nature of CMAC limits conflicts of interest that could be of concern if these functions were transferred to the Agency, regardless of the specific administration that may be in office. If there is no insulation between the negotiator and payer functions, inpatient hospital rates may be driven by more narrow fiscal concerns, potentially without sufficient consideration of critical access standards.

HHS 01
Transform Eligibility Processing

CAPH has a series of concerns about the extent to which the CPRís proposed changes in the eligibility process would result in qualified people not receiving the Medi-Cal benefits for which they are eligible. The current eligibility and enrollment process certainly warrants improvement, as counties, advocates and enrollees have expressed for some time. However, the suggestion to truncate the process by combining programs (Medi-Cal, CalWORKs and Food Stamps) and limiting access to enrollment to an Internet-based system may create too small a funnel through which to fit a large and diverse population. It is also not assured that transferring responsibility from the counties to the state would in itself improve the system, as that move may not address the fundamental issues of access to and complexity of the eligibility and enrollment process.

For instance, the proposed reliance on the Internet may not be realistic for many members of this population and could result in an increase in children and families not getting the services for which they are eligible. While it is possible that moving to an Internet-based eligibility system would improve access for a certain segment of the population, it is also the case that many low-income Californians do not have ready access to the Internet and cannot depend on it as their primary avenue into these public programs. Use of the Internet for eligibility and enrollment should be viewed as only one element of a comprehensive plan that is needed to ensure that eligible persons are enrolled in Medi-Cal.

The Healthy Families application system, held up as a model by the CPR, bears many instructive lessons. The experience of that program suggests that a broad and well-developed infrastructure is needed to assist and enroll families and individuals properly. That function would exceed the capacity of an Internet application, even with reinstatement of payment of a nominal fee to application assistors, to include outreach and education efforts at schools, clinics, through cities, counties and community-based organizations, as well as the infrastructure to allow support and follow-up for families to address questions and issues that arise in the enrollment process following submission of an application.

It is also important to recognize that the Medi-Cal eligibility rules are substantially more complicated than those of the Healthy Families program. One of the main reasons for the enrollment successes of that program is that the burden for both beneficiaries and administrators is far less than for Medi-Cal. For example, the Medi-Cal system has approximately 160 aid codes, which operate under varying

sets of eligibility rules and guidelines. Centralizing processing of applications would not remove the inherent complexities of Medi-Cal eligibility.

Given the complicated nature of the three programs under discussion, and the wide-ranging needs of the applicants, the CPR proposal lacks sufficient detail to confirm that the programsí integrity, access and transparency would be preserved and improved under the new system.

As one step toward simplifying the Medi-Cal eligibility process, CAPH supports the recommendation to adopt self-certification of assets, and suggests that should apply to all beneficiaries.

HHS 30
Centralize Medi-Cal Treatment Authorization Process

CAPH believes that without fundamental changes to the treatment authorization request (TAR) system, centralizing the process could exacerbate existing problems. Problems with the current system include inordinate delays in processing TARs, unwarranted denials for medically necessary services, and lack of consistently applied criteria to adjudicate TARs. Together, these problems lead to payment delays long after services are rendered, wasted hospital and state resources related to inappropriately denied services, and ineffective management of fraud. The current TAR system forces public hospitals to redirect limited resources that otherwise would be focused on patient care.

CAPH is pleased that the CPR recognizes the inadequacies of the current TAR system. However, we believe that an overhaul is required to modernize the system, including:

1. Reducing the number of TARs required by conducting sampling as required in legislation accompanying the 2004-05 Budget Act and by adopting other industry standards.

2. Developing a standard set of adjudication guidelines rather than using the arbitrary application of current ambiguous and out-of-date Medi-Cal criteria.

3. Developing alternative review processes for fraud and abuse detection such as the use of sophisticated claims algorithms.

4. Eliminating any TARs that are not cost effective.

Centralization of staff without an overhaul of the TAR system could lead to further payment delays without generating General Fund savings.

HHS 31
Medi-Cal Fraud Targeting Misses the Mark

CAPH supports better targeting of anti-fraud efforts within the Medi-Cal program and agrees with the CPRís conclusion that ìenrollment and re-enrollment laws and regulationsÖare having a negative effect on all providersÖ.î The current enrollment framework has substantially increased the administrative burden for public hospitals, which must submit separate paperwork to maintain enrollment of each individual practitioner. This results in the submission of hundreds or thousands of

application packages per county to ensure that current doctors and other practitioners can continue to provide needed Medi-Cal services. This process is onerous for public agencies such as public hospitals, which are already subject to extensive public scrutiny. CAPH specifically concurs with Recommendation D that DHS should revamp the enrollment process to focus on identified fraud targets. Reducing administrative burden would allow public hospitals to focus limited resources on patient care.

HHS 28
Improve Integrity in Medi-Cal Through the Use of Smart Cards

The recommendation to require Medi-Cal patients to submit to fingerprinting at each provider encounter is inappropriate and raises questions about discrimination and the inference that large numbers of Medi-Cal enrollees are engaged in fraudulent activity. First, the climate that would be created at a doctorís office, hospital or clinic ó where some patients must submit to fingerprinting while others do not ó would not foster the necessary caring environment for the delivery of medical services. Providersí first and foremost responsibility is to treat the health care needs of their patients, and requiring them to take on a primary role in fraud detection will hinder the fulfillment of that role. Second, most Medi-Cal fraud does not take place at the patient level, so it is unlikely that the suggested benefits of the program would outweigh the costs of imposing the requirements contained in the recommendation. Third, a new system of gathering and recording fingerprints would impose an undue burden on Medi-Cal providers and could act as a disincentive to treat Medi-Cal patients, worsening the provider shortage that already exists.

Transferring Authority for Programs in the Department of Managed Health Care to the Health and Human Services Agency (page 15)

This recommendation appears to conflict with other policy changes under consideration by the Administration, such as the proposal in the ìMedi-Cal redesignî process to expand the use of Medi-Cal managed care among the aged, blind and disabled population. It seems counterintuitive to diminish the role of consumer protection and potentially dilute the function of the HMO industry-watchdog at the same time as the stateís most vulnerable population could become managed care patients. If the managed care expansion takes place, there will be a greater need for consumer information and protection. Enforcement of the Patient Bill of Rights will assume paramount importance, as patients with severe disabilities attempt to navigate the HMO system. The Department of Managed Health Care should be preserved to fulfill that function.

If it were instead subsumed into a newly configured Department of Health and Human Services, Californians would lose an agency focused on protecting their rights as consumers. As a new and improved government agency, DMHC should be looked to as a model for some of the changes contemplated by the CPR ñ accountability, efficiency, responsiveness to the public. It should not be collapsed into a massive super-agency, where it would be forced to compete for attention and resources with licensing, childcare and a range of other issues.